DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING _____ B. WING _____	C 01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN 46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00084499. Complaint IN00084499 - Substantiated, federal/state deficiencies related to the allegation are cited at F-323 and F-514. Survey dates: January 13, 14, and 19, 2011 Facility number: 000192 Provider number: 155295 AIM number: 100291120 Survey team: DeAnn Mankell, R.N. Census bed type: SNF/NF: 69 Total: 69 Census payor type: Medicare: 13 Medicaid: 45 Other: 11 Total: 69 Sample: 3 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 1-24-11 Cathy Emswiller RN	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

RECEIVED
FEB - 4 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

ENTERED FEB 8 2011

approved 2/9/11 pf

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director February 2, 2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have interventions in place and to change the interventions when falls occurred to prevent falls with injuries, which included bruises, lacerations with stitches and staples, skin tears, and a C 1 (neck fracture) fracture, for 2 of 3 resident with falls in a sample of 3 (Residents A and B). Findings include: 1. Resident B's closed clinical record was reviewed on 1/13/11 at 2:06 P.M. Resident B's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), IDDM (insulin dependent diabetes mellitus), HTN (hypertension), ASHD (arteriosclerotic heart disease), depression, seizure disorder, and hypersomnia (narcolepsy [falling asleep rapidly and frequently]). Resident B was readmitted to the facility on 11/30/10. Resident B's "Nursing Admission Assessment" dated 11/30/10 indicated she was full weight bearing and needed one person assist for transfers. She used a walker and wheelchair for mobility assistance. She had a history of falls in the last 30 days and the last 2-6 months, but had	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F323** *It is the policy of this facility to keep the resident environment as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.* Resident A has been assessed by the IDT with an appropriate care plan developed and implemented to address the resident's current safety needs. Resident B no longer resides in the facility. Residents with a history of falls and/or at high risk for falls have the potential to be affected. The IDT will assess residents to determine fall risk potential and develop/ implement individualized plan of care to address residents current safety needs as appropriate.	

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F 323	Continued From page 2 not received a fracture during the falls. The "Side Rail Assessment" dated 11/30/10 indicated low bed and soft mat on the floor where not checked indicating these interventions were not in place. The "Fall Risk Assessment" dated 11/30/10 indicated a total score of 18. The key for the assessment indicated "Total score above 10 represents HIGH RISK." The "Medicare/HMO (health maintenance organization) Skilled Documentation Flow Sheet" dated 12/3/10 indicated Resident B was independent or assisted by request in the toilet. The "Change of Condition Report-Sustained or Suspected Fall" dated 12/3/10 at 2:50 A.M., indicated Resident B had a witnessed fall during a self-transfer in her bathroom. The resident said her legs "gave out" The preliminary investigation of possible contributing factors relating to the fall and additional circumstance related to this fall indicated she was barefoot. The resident had an external head injury. The "post-fall actions initiated were "vital signs and neurological assessment." The Post-Fall Documentation Flow Sheet dated 12/3/10 at 11:30 A.M., indicated Resident B had "swelling to the back of head." The Physician's orders dated 12/3/10 indicated an order to "D/C (discontinue) PT (physical therapy) & OT (occupational therapy)" and a second order to "Admit to Memory Care Unit." The Fall Risk Care Plan dated 11/30/10 had the	F 323	Staff will be re-educated on falls management including selection of appropriate safety measures to meet the needs of the resident and updating the plan of care as necessary. The DON and/or Designee will monitor during routine rounds to ensure that continued compliance is obtained. This monitoring will be done through IDT rounds. This area will be reviewed weekly 5x week for one month, then weekly x4, then monthly through random audits and IDT rounds. Results of the audits will be reported monthly to the QA team for review. The QA committee will review ongoing.	February 16, 2010

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F 323	Continued From page 3 problem of "At risk for falls and inturies (sic) R/T (related to): Medication: Diuretic meds, Cardiovascular meds. Medical Factors: Seizure disorder, Cognitive Impairment, Dementia, Poor safety awareness, Visual impairment, Weakness, Hx of falls. The interventions included, but were not limited to, keep call light within reach, Provide verbal safety cues, pressure sensor pad in (nothing marked). The interventions were updated on 12/3/10 with Pt. moved to MCU (Memory Care Unit). Gait belt to be utilized for all pt transfers et ambulation." The "IDT (interdisciplinary team) post-occurrence review" form dated 12/6/10 indicated the section for "Safety Risk" had no new safety issue identified. "Review safety devices in use or those potentially in need related to this occurrence" had wanderguard, chair alarm, and bed alarm checked. The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form indicated "On 12/3/10 Resident was standing in front of toilet stated 'knees became weak & wouldn't hold er' fell backwards. No (indicated by a circle with a line through it) apparent injury...." During an interview with the DON on 1/19/11 at 10:45 A.M. she indicated Resident B was instructed on safety and to use the call light when she needed to use the bathroom. The "Fall Risk Assessment" dated 12/7/10 indicated a total score of 19. The key for the assessment indicated "Total score above 10 represents HIGH RISK." The "Medicare/HMO Skilled Documentation Flow Sheet" dated 12/12/10 at 9:05 P.M. indicated	F 323		

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F 323	Continued From page 4 "Resident's alarm sounding, resident was sitting on the edge of her bed. Resident then scooted to end of bed attempting to reach her walker, couldn't reach it sat of floor.... witnessed by CNA...." During an interview with the DON on 1/19/11 at 10:48 A.M. she indicated there was no additional documentation regarding this fall. The "Fall Risk Assessment" dated 12/14/10 indicated a total score of 20. The key for the assessment indicated "Total score above 10 represents HIGH RISK." The "Change of Condition Report-Sustained or Suspected Fall" dated 12/15/10 at 11:15 P.M., indicated Resident B had a witnessed fall as she was sitting on the toilet. She had an external head injury. She was unable to tell the staff what had happened. The preliminary investigation of possible contributing factors relating to the fall and additional circumstance related to this fall was blank. The "post-fall actions initiated were "neurological assessment and transfer to the hospital." The nurses' notes dated 12/15/10 at 11:15 P.M., indicated "Res. fell forward from toilet. Hit head on w/c. Laceration noted on scalp. Res. keeps falling asleep during assessment...." The physician's orders dated 12/15/10 indicated "May send to (name) ER for eval (evaluation) et (and) tx (treatment)." The ER report indicated on 12/16/10 was admitted to the ER. She had a laceration to her scalp which was closed with staples and she	F 323		

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F 323	Continued From page 5 returned to the facility. The "Episodic Care Plan: Post-Fall" dated 12/15/10 had a problem of "sustained fall - fell from toilet - witnessed." There was a notation of 12/16/10 of "Res. falls asleep @ anytime." The goal was "Res. will have no falls r/t (related to) falling asleep while sitting in chair/toileting X 90 days. The interventions included, but were not limited to, "Do not leave res. unattended in BR. Be sure alarms are on when in bed or w/c. Alarmed seatbelt to be placed on w/c. When res. in room alone in w/c - keep bedside table in front of her. Keep call light in reach. Encourage using bed pan @ noc (night)." The physician's orders date 12/16/10 indicated an order for "May place a self release belt alarm on res. w/c for safety r/t falls." The "IDT (interdisciplinary team) post-occurrence review" form dated 12/20/10 indicated the section for "Review potential contributing factors related to this occurrence" indicated the "resident has dx dementia. will attempt self transfers." "Safety Risk" had no new safety issue identified. "Review safety devices in use or those potentially in need related to this occurrence" had bed alarm and self-releasing seat belt checked. Nite light and gripper socks was hand written on the form. The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form indicated "Resident was on toilet & fell forward, CNA unable to intervene...." The Fall Risk Care Plan dated 11/30/10 and updated on 12/20/10 had the problem of "At risk for falls...." The interventions were updated on 12/20/10 with the addition of "night light in BR	F 323		

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F 323	Continued From page 6 (bathroom) and gripper socks @ HS (bedtime)." During an interview with the DON on 1/19/11 at 10:50 A.M. she indicated during the investigation of the fall the CNA told the DON she didn't know the resident had narcolepsy and could fall asleep sitting up on the toilet. The "Fall Risk Assessment" dated 12/21/10 indicated a total score of 20. The key for the assessment indicated "Total score above 10 represents HIGH RISK." The January 2011 Physician's Orders indicated orders for "Pressure sensitive alarm in wc and bed. Check placement & function every shift" first written on 11/30/10, "May place a self release belt alarm on res wc for safety r/t falls" first written on 12/16/10. The nurses' notes dated 1/7/11 at 1:30 A.M. indicated "Res. alarm sounding. Writer ran to res. room.. Writer found res. on floor by bed laying in blood.... Writer asked res what happened. 'Res stated she rolled out of bed'.... her forehead hurt...." Review of the ER notes dated 1/7/11 indicated Resident B was admitted to the ER with "open wound of face." She complained of neck pain. A CT scan completed on 1/7/11 of her neck indicated at the C 1 (cervical vertebra 1) "probable nondisplaced transverse dens fracture (neck fracture)." She was transferred to a different hospital and admitted for treatment. 2. During the facility tour on 1/13/2011 at 11:50 A.M., with LPN # 1, Resident A was identified as being at risk for falls and having fallen in the past	F 323		

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F 323	Continued From page 7 month. Resident A's clinical record was reviewed on 1/13/2011 at 12:25 P.M. Resident A's diagnoses included, but were not limited to Parkinson's disease, dementia, atypical psychosis, depression, restless leg syndrome, anxiety, hypertension, and migraine headaches. Resident A's daughter was her guardian. Resident A was observed in her room on 1/14/11 at 1:09 P.M. She was sitting in her wheelchair staring into space. There were anti-tipper bars on the front and the back of the wheelchair. The brakes on the wheelchair were locked and the resident was rocking the wheelchair back and forward as she talked. There was a seatbelt around the resident's waist. There was a mat on the floor next to the bed which had an alarm attached to it. The resident was asked about her falls. She answered that she doesn't use the call light because "it takes them 15-30 minutes to answer it." Resident A's "Fall Risk Care Plan" dated 3/29/10, 4/21/10, 5/22/10, 6/16/10, 7/8/10,, 7/23/10, 7/31/10, for the problem of "At risk for falls and inturies (sic) R/T (related to) Medications: antidepressants & antianxiety, incontinence, Parkinson's, unsteady gait, dementia, weakness, fall 4/3/10." The interventions included, but were not limited to, "provide adequate lighting, monitor side effects of meds, keep call light within reach, encourage use of call light, monitor for unsteady gait and balance, labs as ordered, assess toileting needs, provide verbal safety cues, keep personal belongings within reach, keep assistive	F 323		

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F 323	Continued From page 8 devices within easy reach - wheelchair, provide non-skid footwear, PT eval and treat if indicated (dated 4/5/10), OT eval and treat if indicated (dated 4/5/10), pressure sensor pad in bed, w/c (d/c [discontinue] 4/5/10), pt to stay in common areas as much as poss (possible) (dated 8/1/10), visual checks x 3 days & psych eval (evaluation) (dated 7/31/10), motion sensor alarm ankel (sic) (dated 7/7/10), referred to OT for w/c (dated 7/7/10), staff instructed to lay pt down after meals (added 7/7/10), and Res. to amb. (ambulate) c (with) gait belt et assist x i (one) to et from meals (added 7/15/10), auto lock w/c brakes (added 7/23/10)." The "Fall Risk Assessment" dated 8/10/10 indicated a total score of 19. The key for the assessment indicated "Total score above 10 represents HIGH RISK." The Nurses' Notes indicated: 8/19/10 9:00 P.M. "Resident fell at 3:30 P.M. Found on floor behind w/c (wheelchair) when alarm sounded, w/c was tipped over. No (indicated by a line crossed through a circle) signs of injury...." The physician's order dated 8/19/10 indicated an order for "back anti-tippers to be placed on w/c." The care plan for falls had the addition of the "back anti-tippers" dated 8/19/10. The "Change of Condition Report-Sustained or Suspected Fall" dated 8/31/10 indicated Resident A had a suspected fall from her chair or wheelchair in her room at 10:45 A.M. The alarm was activated. She obtained a red area measuring 20 cm. to the left side of her forehead.	F 323		

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F 323	Continued From page 9	F 323		

The "IDT (interdisciplinary team) post-occurrence review" form dated 9/1/10 indicated on 8/31/10 the resident "fell from w/c while trying to stand alone. Alarm sounded, CNA witnessed res. fall. The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form indicated "Pt. sitting in w/c in rm (room) et was observed standing up (indicated by an arrow pointing up) from w/c alarm was sounding. Spoke c therapy r/t (related to) pt legs giving out. Therapy stated this will be a chronic problem. Pt placed on ambulation program to et from dining rm. (room)."

The fall care plan dated 3/29/10 indicated the intervention of "Res. to amb. (ambulate) c (with) gait belt et assist x i (one) to et from meals." had been added on 7/15/10.

Resident A's September 2010 "Physician's Order" had the following orders and the date each was first written:
"Motion sensor alarm on bed" 7/08/10
"Res. to ambulate with gait belt and assist of one to and from meals." 7/15/10
"Auto lock brakes to w/c." 7/23/10
"Back anti tippers to be placed on w/c." 8/19/10

There was a physician's order dated 9/6/10 with orders to "1. D/C (discontinue) motion sensor alarm to bed. 2. Pressure sensitive pad to w/c et bed. Check functioning et placement Q. (every) shift."

There was an "IDT (interdisciplinary team) post-occurrence review" form dated 9/9/10 which indicated the safety device in use was an "alarming mat @ bedside."

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F 323	Continued From page 10 The "Fall Risk Assessment" dated 9/23/10 indicated a total score of 18. The key for the assessment indicated "Total score above 10 represents HIGH RISK." The quarterly MDS (minimum data set) assessment dated 9/29/10 indicated Resident A was moderately impaired with poor decisions; cues/supervision required. She needed extensive assistance of one person to transfer, walk in the room and hallway, eat, dress, bathe, and use the toilet. She was assessed as being unable to balance while standing, or sitting without physical help. She was assessed as having unsteady gait and having fallen in the past 31-180 days. The "Change of Condition Report-Sustained or Suspected Fall" dated 11/1/10 indicated Resident A had a suspected fall from her chair or wheelchair in her room at 9:15 A.M., during an assisted transfer. Resident A was leaning out of her chair and fell. The alarm was activated. She had no injuries. The "IDT (interdisciplinary team) post-occurrence review" form dated 11/1/10 indicated " was leaning forward in chair, fell out, hit head on bed c no sx (signs) of injury." The interventions in use were "pressure sensitive alarm to bed/chair. Mat on floor next to bed." The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form was blank. During an interview with the DON on 1/19/11 at 10:00 A.M., she indicated Resident A had a urinalysis and EEG (electroencephalogram) done after this fall. She was treated for a urinary tract infection. The results of the EEG dated 11/2/10	F 323		

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F 323	Continued From page 11 were "Technically unsatisfactory EEG because of excessive muscle/movement artifact." The "Fall Risk Assessment" dated 11/10/10 indicated a total score of 18. The key for the assessment indicated "Total score above 10 represents HIGH RISK." The "Change of Condition Report-Sustained or Suspected Fall" dated 11/11/10 indicated Resident A had a suspected fall from her chair or wheelchair in her room at 11:10 A.M., during a self- ambulation/self-transfer. The preliminary investigation of possible contributing factors relating to the fall and additional circumstance related to this fall indicated the alarm was not activated. There was a notation of "resident shut off" next to the alarm. She had no injuries. During an interview with the DON on 1/19/11 at 10:10 A.M., she indicated the facility investigation had determined the resident told the staff she had fallen. She told them she had turned off the alarm, gotten up, fallen, and gotten up and walked to the toilet where the CNA had found her. She indicated the facility's intervention was to re-educate the resident to call for assistance. The physician's order dated 11/11/10 indicated "Pt to be (I) (independent) amb (ambulation) c (with) assist x i (one)." The "Fall risk care plan" dated 3/29/10 had additional interventions dated 11/11/10 of "visual checks x 3 days and pt to be (I) (independent) c (with) assist x i (one)." The Nurses' notes indicated: 11/15/2010 8:10 P.M. "Resident was sitting in w/c	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12 watching t.v. as writer walked by alarm sounded, found resident sitting on floor with w/c tipped over.... Three small reddned (sic) areas on each elbow et base of neck...." The "Change of Condition Report-Sustained or Suspected Fall" dated 11/15/10 at 8:15 P.M. indicated Resident A had a suspected fall from her chair or w/c in her room while she was "trying to adjust the t.v. volume." The preliminary investigation of possible contributing factors relating to the fall and additional circumstance related to this fall was blank. The resident had no apparent injuries. The "IDT (interdisciplinary team) post-occurrence review" form dated 11/17/10 indicated the section for "Review safety devices in use or those potentially in need related to this occurrence:" had "front antitippers" written in the blank. The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form indicated "Resident was sitting in rm. in w/c watching TV alarm was sounding pt was sitting beside the bed c chair tipped over. Stated she was trying to adjust TV volume." The "Change of Condition Report-Sustained or Suspected Fall" dated 11/26/10 at 12:15 A.M., indicated Resident A had a suspected fall from her bed in her room reaching for an object. The alarm failed to sound. The resident had a laceration and was transported to the ER. The hand written note on the form indicated "Resident was found on the floor on (R) (right) side c a puddle of blood under her head. Res. stated 'I was leaning over to get a cough drop off the floor when I fell.' When asked stated 'I hit my head of the trash can.'"	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING _____ B. WING _____	C 01/19/2011

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F 323	Continued From page 13 The physician's order dated 11/26/10 indicated. "Send to (name) ER for evaluation &tx. (treatment)." The nurses' notes indicated 11/26/10 9:00 A.M. "Returned from hospital at 7:30 A.M. Sutures to (R) temporal area. 2.6 cm. laceration...." The physician's order dated 11/26/10 indicated, "Low bed c mat." The "Change of Condition Report-Sustained or Suspected Fall" dated 11/26/10 at 10:15 P.M., indicated Resident A had a suspected fall from her chair or w/c in her room reaching for an object. The alarm failed to sound or was removed. The resident slid to the floor with no apparent injuries. The hand written note on the form indicated "Resident was found lying on back on floor. Denies hitting head no (indicated by a circle with a line through it) bumps or discolorations noted. Resident stated 'I was going after another cough drop.'" During an interview with the DON on 1/19/11 at 10:20 A.M., she indicated the intervention was to make sure the residents trash can was within reach and the facility had gotten the resident a reacher. The "Fall risk care plan" dated 3/29/10 had an intervention of "Keep personal belongings within reach" on the care plan. The "Fall Risk Assessment" dated 11/27/10 indicated a total score of 21. The key for the assessment indicated "Total score above 10 represents HIGH RISK."	F 323		

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F 323	Continued From page 14 The "Change of Condition Report-Sustained or Suspected Fall" dated 11/30/10 at 4:00 P.M., indicated Resident A had a suspected fall from a sitting position from her w/c reaching for an object. The alarm sounded. She had no apparent injuries. The "IDT (interdisciplinary team) post-occurrence review" form dated 12/1/10 indicated the section for "Review safety devices in use or those potentially in need related to this occurrence" was blank. The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form indicated "On 11/30/10 Resident sitting in w/c - fell forward from sitting position. Alarm was activated & sounding - no (indicated by a circle with a line through it)...." The "Change of Condition Report-Sustained or Suspected Fall" dated 12/8/10 at 5:00 P.M., indicated Resident A had a suspected fall from her w/c during a self-transfer in her room as she was trying to stand. The alarm was sounding. She had no injuries. The "IDT (interdisciplinary team) post-occurrence review" form dated 12/9/10 indicated the section for "Review safety devices in use or those potentially in need related to this occurrence" had chair alarm and bed alarm checked. The notation was "bed & chair alarm intact & activated." The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form indicated "Resident c (with) poor safety awareness, h/o (history of) falls....NO (new order) to dc (discontinue) sensitive alarms & apply self releasing alarming seat belt."	F 323		

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F 323	Continued From page 15 The physician's order dated 12/9/10 indicated an order for "self releasing alarm belt." The "Change of Condition Report-Sustained or Suspected Fall" dated 12/11/10 at 2:03 P.M., indicated Resident A had a suspected fall from her chair or w/c in her room reaching for an object. She lost her balance. The alarm was activated. She had skin tears on the left hand. The post-fall actions initiated where "post fall neurological assessment, provided safety re-education, reinforced using call light for assistance, and oxygen saturation measured." The nurses' notes dated 12/11/10 at 2:03 P.M. indicated "Alarm sounding when arrive in res room, res was laying on floor on back. Res stated she was trying to open blinds & fell back on bed. The bed moved & she fell to the floor...." During an interview with the DON on 1/19/11 at 10:30 A.M. she indicated she had not reviewed that fall. During a second interview with the DON on 1/19/11 at 1:50 P.M. she indicated she had no additional information regarding interventions for the 12/11/10 fall. The "Fall Risk Assessment" dated 12/11/10 indicated a total score of 16. The key for the assessment indicated "Total score above 10 represents HIGH RISK." The "Fall Risk Assessment" dated 12/21/10 indicated a total score of 16. The key for the assessment indicated "Total score above 10 represents HIGH RISK."	F 323		

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F 323	Continued From page 16 The annual MDS (minimum data set) assessment dated 12/22/10 indicated Resident A was assessed as being moderately impaired for decision making with poor decisions and cues/supervision required. She needed extensive assistance of one person to transfer from the bed or chair to a standing position, walk in her room or the hallway, use the toilet, and bathe. She was assessed as being "not steady, only able to stabilize with human assistance for balance during transitions and walking. She had a walker and a wheelchair for assistive devices. The physician orders dated 12/23/10 indicated "Order clarifications 1. Pressure sensitive alarming mat @ bedside, check function et placement q. (every) shift. 2. Pressure sensitive alarm to wc, check placement et functioning every shift. 3. D/C (discontinue) orders for low bed c mat." The "Change of Condition Report-Sustained or Suspected Fall" dated 12/28/10 at 3:20 P.M., indicated Resident A had a suspected fall from her w/c in her room. The preliminary investigation of possible contributing factors relating to the fall and additional circumstance related to this fall was blank. The resident had a red scalp. The "post-fall actions initiated were "observation, safety re-education, reinforced using call light for assistance." There was a notation of "Resident stated, 'I was being negligent and popped wheeles (sic) in my w/c.'" The physician's orders dated 12/28/10 indicated "1. Anti-tippers on rear of w/c." The "IDT (interdisciplinary team) post-occurrence review" form dated 12/29/10 indicated the section	F 323		

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F 323	Continued From page 17 for "Review safety devices in use or those potentially in need related to this occurrence" had pressure alarm, chair alarm, and bed alarm checked. The notation was "back anti tippers placed." The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form indicated "Resident was sitting in w/c in room prior to being observed on the floor...." During an interview with the DON on 1/19/11 at 10:40 A.M. she indicated she did not know what had happened to the back anti-tippers, but she indicated they had not been on the wheelchair when Resident A had fallen and were placed after this fall. The care plan dated 12/29/10 for the problem of "At risk for falls and inturies (sic) r/t medication: psychotropic meds, cardiovascular meds, pain meds, antianxiety-antidepressants, incontinence, unsteady gait, pain, dementia, poor safety awareness, hx (history) of falls." The interventions included, but were not limited to, "provide adequate lighting, keep call light within reach, monitor for unsteady gait and balance, keep personal belongings within reach, keep assistive devices within easy reach, provide non-skid footwear, PT eval and treat if indicated, OT eval and treat if indicated, pressure sensor pad in w/c, floor, mat at bedside when in bed. antitippers on w/c, self-releasing alarm belt, auto locks w/c, and ambulate to meals." The January 2011 physician's orders indicated the following orders: "Res. to ambulate with gait belt and assist of one to and from meals" first written on 7/15/10, "Auto lock brakes to w/c" first written on 7/23/10,	F 323		

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F 323	Continued From page 18 "Low bed with mat" first written on 11/26/10, "Self releasing alarm belt" first written on 12/09/10, "Pt to be independent ambulation with assist X one" first written on 11/11/10, "Anti-tippers rear of w/c, pressure sensitive alarming mat @ bedside, check functioning & placement q. shift, pressure sensitive alarm to wc, check placement & functioning q. shift," The "Change of Condition Report-Sustained or Suspected Fall" dated 1/12/11 at 12:00 P.M., indicated Resident A had a fall as she was being assisted to the bathroom with a CNA. The statement on the form indicated " CNA ambulating res. to BR (bathroom) - Res. lost balance et fell back, hit (L) (left) shoulder on door - causing red area 4 cm x 2.5 cm. res did not hit head...." The CNA assignment sheet dated 1/13/2011 indicated Resident A was to have "bed & chair alarms" and she was to have "Assist of 1 for ADLs (activities of daily living) and Transfers do not lock w/c when in rm (room). Interview with DON on 1/19/11 at 10:45 A.M. she indicated the CNA's on the day shift on the resident's hall were inserviced regarding the use of a gait belt for ambulation. Review of the policy and procedure for "Use of Gait Belt," dated 2008, provided by the administrator on 1/19/11 at 1:50 P.M., indicated: "Policy It is the policy of this facility that staff will help control and balance (by using a gait belt) residents who require assistance with ambulation and transfer.	F 323		

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F 323	Continued From page 19 Purpose To help control and balance resident during assisted transfer or ambulation." Review of the "Falls Management," dated October 2010, provided by the administrator on 1/19/11 at 1:50 P.M., indicated: "Purpose. To evaluate risk factors and provide interventions to minimize risk, injury, and occurrences.... Fall Prevention Equipment may include, but is not limited to: Alarms, sensor mats, transfer poles, floor pads, non-skid mats, hand rails, grab bars, trapeze, adaptive equipment, transfer lifts, etc.... Regularly review, revise, and evaluate care plan effectiveness at minimizing falls and injuries...." This federal tag relates to complaint IN00084499.	F 323		
F 514 SS=D	3.1-45(a)(2) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	**F514** *It is the policy of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices.* Due to the passage of time there is no opportunity to correct the documentation of fall circumstances related to past falls. Resident B no longer resides in this facility. Residents with a history of falls have the potential to be affected. The medical records will be	

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F 514	Continued From page 20 by: Based on interview and record review, the facility failed to have complete documentation related to how falls occurred and the interventions put into place after the falls occurred for 2 of 3 resident with falls in a sample of 3 (Residents A and B). Findings include: 1. Resident B's closed clinical record was reviewed on 1/13/11 at 2:06 P.M. Resident B's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), IDDM (insulin dependent diabetes mellitus), HTN (hypertension), ASHD (arteriosclerotic heart disease), depression, seizure disorder, and hypersomnia (narcolepsy [falling asleep rapidly and frequently]). The "Change of Condition Report-Sustained or Suspected Fall" dated 12/3/10 at 2:50 A.M., indicated Resident B had a witnessed fall during a self-transfer in her bathroom. The resident said her legs "gave out" The preliminary investigation of possible contributing factors relating to the fall and additional circumstance related to this fall indicated she was barefoot. The resident had an external head injury. The "post-fall actions initiated were "vital signs and neurological assessment." The "IDT (interdisciplinary team) post-occurrence review" form dated 12/6/10 indicated the section for "Safety Risk" had no new safety issue identified. "Review safety devices in use or those potentially in need related to this occurrence" had wanderguard, chair alarm, and bed alarm checked. The "IDT	F 514	reviewed to ensure current safety measures are in place to meet the need of the resident. The staff will be re-educated on the proper completion of forms and fall documentation and the updating of care plans. Fall documentation will be reviewed the next business day in conjunction with daily rounds. The DON and/or Designee will review fall documentation and fall care plans 5x weekly x one month, then weekly x1month, and then monthly. The results will be reported weekly by the DON to the IDT team for review. Results will be also monitored monthly by QA Committee and ongoing.	February 16, 2010

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F 514	Continued From page 21	F 514		

notes/recommendations/targeted plan to prevent recurrence" section of the form indicated "On 12/3/10 Resident was standing in front of toilet stated 'knees became weak & wouldn't hold er' fell backwards. No (indicated by a circle with a line through it) apparent injury...."

During an interview with the DON on 1/19/11 at 10:45 A.M. she indicated Resident B was instructed on safety and to use the call light when she needed to use the bathroom.

The "Medicare/HMO Skilled Documentation Flow Sheet" dated 12/12/10 at 9:05 P.M. indicated "Resident's alarm sounding, resident was sitting on the edge of her bed. Resident then scooted to end of bed attempting to reach her walker, couldn't reach it sat of floor.... witnessed by CNA...."

During an interview with the DON on 1/19/11 at 10:48 A.M. she indicated there was no additional documentation regarding this fall.

The "Change of Condition Report-Sustained or Suspected Fall" dated 12/15/10 at 11:15 P.M., indicated Resident B had a witnessed fall as she was sitting on the toilet. She had an external head injury. She was unable to tell the staff what had happened. The preliminary investigation of possible contributing factors relating to the fall and additional circumstance related to this fall was blank. The "post-fall actions initiated were "neurological assessment and transfer to the hospital."

2. Resident A's clinical record was reviewed on 1/13/2011 at 12:25 P.M.

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F 514	Continued From page 22	F 514		

Resident A's diagnoses included, but were not limited to Parkinson's disease, dementia, atypical psychosis, depression, restless leg syndrome, anxiety, hypertension, and migraine headaches.

The "Change of Condition Report-Sustained or Suspected Fall" dated 11/1/10 indicated Resident A had a suspected fall from her chair or wheelchair in her room at 9:15 A.M., during an assisted transfer. Resident A was leaning out of her chair and fell. The alarm was activated. She had no injuries.

The "IDT (interdisciplinary team) post-occurrence review" form dated 11/1/10 indicated " was leaning forward in chair, fell out, hit head on bed c no sx (signs) of injury." The interventions in use were "pressure sensitive alarm to bed/chair. Mat on floor next to bed." The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form was blank.

During an interview with the DON on 1/19/11 at 10:00 A.M., she indicated Resident A had a urinalysis and EEG (electroencephalogram) done after this fall. She was treated for a urinary tract infection. The results of the EEG dated 11/2/10 were "Technically unsatisfactory EEG because of excessive muscle/movement artifact."

The "Change of Condition Report-Sustained or Suspected Fall" dated 11/11/10 indicated Resident A had a suspected fall from her chair or wheelchair in her room at 11:10 A.M., during a self- ambulation/self-transfer. The preliminary investigation of possible contributing factors relating to the fall and additional circumstance related to this fall indicated the alarm was not activated. There was a notation of "resident shut

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F 514	Continued From page 23 off" next to the alarm. She had no injuries. During an interview with the DON on 1/19/11 at 10:10 A.M., she indicated the facility investigation had determined the resident told the staff she had fallen. She told them she had turned off the alarm, gotten up, fallen, and gotten up and walked to the toilet where the CNA had found her. She indicated the facility's intervention was to re-educate the resident to call for assistance. The Nurses' notes indicated: 11/15/2010 8:10 P.M. "Resident was sitting in w/c watching t.v. as writer walked by alarm sounded, found resident sitting on floor with w/c tipped over.... Three small reddned (sic) areas on each elbow et base of neck...." The "Change of Condition Report-Sustained or Suspected Fall" dated 11/15/10 at 8:15 P.M. indicated Resident A had a suspected fall from her chair or w/c in her room while she was "trying to adjust the t.v. volume." The preliminary investigation of possible contributing factors relating to the fall and additional circumstance related to this fall was blank. The resident had no apparent injuries. The "IDT (interdisciplinary team) post-occurrence review" form dated 11/17/10 indicated the section for "Review safety devices in use or those potentially in need related to this occurrence:" had "front antitippers" written in the blank. The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form indicated "Resident was sitting in rm. in w/c watching TV alarm was sounding pt was sitting beside the bed c chair tipped over. Stated she was trying to adjust TV volume."	F 514		

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F 514	Continued From page 24 The "Change of Condition Report-Sustained or Suspected Fall" dated 11/26/10 at 12:15 A.M., indicated Resident A had a suspected fall from her bed in her room reaching for an object. The alarm failed to sound. The resident had a laceration and was transported to the ER. The hand written note on the form indicated "Resident was found on the floor on (R) (right) side c a puddle of blood under her head. Res. stated 'I was leaning over to get a cough drop off the floor when I fell.' When asked stated 'I hit my head of the trash can.'" The physician's order dated 11/26/10 indicated, "Low bed c mat." The "Change of Condition Report-Sustained or Suspected Fall" dated 11/26/10 at 10:15 P.M., indicated Resident A had a suspected fall from her chair or w/c in her room reaching for an object. The alarm failed to sound or was removed. The resident slid to the floor with no apparent injuries. The hand written note on the form indicated "Resident was found lying on back on floor. Denies hitting head no (indicated by a circle with a line through it) bumps or discolorations noted. Resident stated 'I was going after another cough drop.'" During an interview with the DON on 1/19/11 at 10:20 A.M., she indicated the intervention was to make sure the residents trash can was within reach and the facility had gotten the resident a reacher. The "Change of Condition Report-Sustained or Suspected Fall" dated 11/30/10 at 4:00 P.M., indicated Resident A had a suspected fall from a	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING _____ B. WING _____	C 01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN 46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 25 sitting position from her w/c reaching for an object. The alarm sounded. She had no apparent injuries. The "IDT (interdisciplinary team) post-occurrence review" form dated 12/1/10 indicated the section for "Review safety devices in use or those potentially in need related to this occurrence" was blank. The "IDT notes/recommendations/targeted plan to prevent recurrence" section of the form indicated "On 11/30/10 Resident sitting in w/c - fell forward from sitting position. Alarm was activated & sounding - no (indicated by a circle with a line through it)...." The "Change of Condition Report-Sustained or Suspected Fall" dated 12/11/10 at 2:03 P.M., indicated Resident A had a suspected fall from her chair or w/c in her room reaching for an object. She lost her balance. The alarm was activated. She had skin tears on the left hand. The post-fall actions initiated where "post fall neurological assessment, provided safety re-education, reinforced using call light for assistance, and oxygen saturation measured." The nurses' notes dated 12/11/10 at 2:03 P.M. indicated "Alarm sounding when arrive in res room, res was laying on floor on back. Res stated she was trying to open blinds & fell back on bed. The bed moved & she fell to the floor...." During an interview with the DON on 1/19/11 at 10:30 A.M. she indicated she had not reviewed that fall. During a second interview with the DON on 1/19/11 at 1:50 P.M. she indicated she had no additional information regarding interventions for	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING _____ B. WING _____	C 01/19/2011

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F 514	Continued From page 26 the 12/11/10 fall. This federal tag relates to complaint IN00084499. 3.1-50(a)(1) 3.1-50(a)(2)	F 514		